State West Virginia

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-D-2

Methods and Standards for Determining Payment Rates for Non-State-Owned Intermediate Care Facilities for Mentally Retarded (Excludes State-Owned ICF/MR Facilities)

I. Cost Finding and Reporting

All intermediate care facilities for the mentally retarded (ICF/MRs) certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Chart of Accounts for Intermediate Care Facilities for the Mentally Retarded, as incorporated in the Users Reimbursement Manual for ICF/MR, must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for ICF/MR must be reported on the Financial and Statistical Report for ICF/MR. These reports must be completed in accordance with generally accepted accounting principles and the accrual method of accounting and must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating ICF/MR facility costs are reported semi-annually. The semi-annual reporting period is January 1st through June 30th and July 1st through December 31st.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within 60 days following the end of the reporting period. The due dates are February 28th for the December 31st closing date and August 31st for the June 30th closing date.

An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances, where requested and justified by the facility in writing, before the closing date. Requests for an extension of the filing period are to be addressed in writing to:

Director, Office of Audit, Research and Analysis
Department of Health and Human Resources
Capitol Complex, Building 6
Charleston, West Virginia 25305

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the sixty days filing period where no extension has been granted to the facility, or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed for each day that the cost report is delinquent, and will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to these penalty provisions. Facilities submitting cost reports after the beginning of the rate period; i.e., April 1st or October 1st, will receive rate increases effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected, and resultant prospective reimbursement rates adjusted if cost data are resubmitted within 30 days after original rate notification. Only those corrections received by the Department within the 30-day period will be considered for rate revision. The Department will make revisions resultant from computational errors in the rate determination process at any time, including at the completion of an audit review.

G. New Facilities - Projected Rates

A projected rate will be established for new ICF/MR facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. Each such facility on a projected rate must submit the mandated cost report during the projected rate period. Beginning with the first full three months of operating experience in a reporting period, a prospective rate will be established in the subsequent rate setting period. No projected rate may exceed twelve (12) months.

H. Change of Ownership - Projected Rates

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility.

Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control. Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting projected rates.

Each such facility on a projected rate must submit the required semi-annual cost reports during the projected rate period beginning with the first 3 months operating experience in a reporting period.

I. Change in Bed Size

Any ICF/MR facility changing bed size must submit the semi-annual cost report beginning with the first three months operating experience in the cost reporting period following the effective date of the change.

J. Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports. Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials.

The State agency will maintain cost reports for a minimum of five (5) years from date of receipt.

II. Allowable Costs

Reimbursement for ICF/MR services is limited to those costs required to provide active treatment to people with mental retardation and related conditions. These are facility operating costs, client direct service costs, and costs for the physical setting.

Allowable Costs for Cost Centers - ICF/MR

Cost center areas are standard services (operating costs), mandated services and

capital. A cost upper limit is developed in the aggregate for standard services and for mandated services, which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

1. Standard Services

Standard services are Dietary, Laundry and Housekeeping, Maintenance, Administration, and Utilities. Cost standards for these services are computed from the current cost report; i.e., salaries (total compensation), supplies and services as submitted by the facilities. Total allowable costs for all clients are arrayed assuming 100% occupancy; i.e., licensed beds times days, to establish a per client day cost. The costs are then arrayed. Extremes are eliminated by including only those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP) which is then adjusted by a 95% occupancy level to establish the cost standard. The cost standard then establishes the maximum allowable cost for the standard services (operating costs).

2. Mandated Services

Mandated services are defined as: Living Unit, Restorative & Activities, Nursing & Medical Records, Resident Transportation, Day Programming, and Taxes & Insurance. Reported allowable cost for these services is fully recognized and reimbursable to the extent it does not exceed the upper limits established by the Department from the reports submitted by the facilities. The upper cost limits are set at the 90th percentile of costs based on an assumed occupancy of one hundred percent and a calendar year of 365 days.

3. Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property, and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Facility Standard, where appropriate. This valuation is the basis for capitalization to determine a per client day cost of capital. This allowance replaced leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting therefrom the

estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indices used are Marshall valuation services and Boeckle Building Valuation Manual.

b. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

(1) Physical deterioration; curable and incurable.
(2) Functional obsolescence; curable and incurable.
(3) Economic obsolescence.

The facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources which include "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities"--HHS Publication No. (HRS) 81-14500 and West Virginia Rules and Regulations for Licensing of Nursing Homes, where appropriate.

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved patient care or cost effective measures which do not compromise patient care.

d. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually prior to the April rate setting period. Updates may be performed at anytime during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes.

A copy of the facility appraisal report is furnished to the facility for its records.

4. Compensation

Compensation, to be allowable, must be reasonable and determined to be for services that are necessary and related to patient care, and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the ICF/MR class. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per year worked in patient-related duties.

Compensation must include the total benefit paid for the services rendered; i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

5. Program Directors

Compensation for directors who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility.

6. Owners

Administrators/owners will be compensated for administrative duties

performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family. Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations which have an equity interest in the facility.

7. Non-Allowable Costs

Bad debt, charity, penalties and fines, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State agency regulations as non-allowable costs.

8. Purchase from Related Companies or Organizations

All related companies or organizations involved in any financial transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the nature and extent of such business transactions.

Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

III. Rate Determination - ICF/MR

Individual facility rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, or reconciliation of audit findings related to falsification of data or overstatement of costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report for ICF/MR.

The rate is subject to desk review and then converted to cost per patient day. The rate shall be based on the facility's reported costs and adjustments for the reporting period January 1, 1997 through June 30, 1997. An inflation adjustment will be made to the

rate for each six month period effective April 1 and October 1 of each year beginning April 1, 1998. The State will provide for periodic re-basing of rates based on the most recent cost report filings. In no case will facility rates, including inflation adjustments, be in effect for more than 2 years without full re-basing.

A. Cost Adjustment

Reported facility costs are subject to review and analysis through desk audit. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies:

1. Standard Services

Reported allowable costs in the standard services area are compared against the aggregate cost standard for these cost centers. If the allowable reported costs exceed the cost standard, then the facility rate is limited to the standard.

2. Mandated Services

Reported allowable cost is fully recognized for these cost centers, provided it does not exceed the upper limits established by the Department. The upper cost limits are set at the 90th percentile of reported allowable costs, based on an assumed occupancy of 100% and a calendar year of 365 days.

3. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology. Capital costs will be updated effective October 1st of each year..

a. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land,

building and equipment.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate to reflect current money values in the mortgage market at the time of original indebtedness. This band of investment sets a 75:25 debt-service to equity ratio.

The interest rate for the mortgage component is based on the Baa State and Local (Baa), plus 2 points (not to exceed 14%), current at the time of the facility's original indebtedness, modified by the use of the constant annual percent for non-profit facilities.

The yield on equity allowance (for proprietary facilities) is based on the average United States Long Term Composite Rate (USLT) current at the time of facility original indebtedness. The yield on appreciation is based on the average United States Long Term Composite Rate (USLT) allowable during the cost reporting period.

b. Capital Allowance

For proprietary ICF/MR facilities the capital allowance per patient day is determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology, and by applying the appreciation factor to the accumulated appreciation as determined by the Standard Appraised Value (SAV) methodology. For non-profit facilities, the capital allowance is determined by applying the capitalization rate for the mortgage component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology.

4. Assumed Occupancy Standard

Ceiling class cost adjustments will be made by applying a minimum occupancy standard of 95% to all cost centers.

5. Minimum Occupancy Level

Allowable cost per patient day will be determined using actual facility occupancy if that occupancy is equal to or greater than 90%. If the actual occupancy level is less than 90%, the per patient day cost will be adjusted to assume a 90% occupancy level.

B. Efficiency Allowance

An Efficiency Incentive will be allowed where the standard service area allowable costs are less than the total of the cost ceiling. Facilities which continue to provide quality services at less than the cost ceiling, may be allowed an opportunity to share in the cost savings.

Fifty percent (50%) of the difference between the total allowable cost and the cost ceiling will be applied to the standard service area. The total of the calculated efficiency incentive may not exceed $4.00 per patient day.

C. Inflation Factor

After combining the various components, a factor is assigned to allowable costs (excluding capital costs) as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs are compared with the CPI. The amount of change experienced during the reporting period or the CPI becomes the inflation factor applied to the next rate setting period. The inflation factor, once set for a given rate period, may be adjusted semi-annually as it represents a reasonable expectation for cost increases.

Indicators used for tracing economic changes and trends include:

1. Annual Cost Reporting

The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.

2. Regulatory Costs

Regulatory costs, such as minimum wage increase, FICA increase,